

U.S. Department of Health and Human Services  
Health Resources and Services Administration  
Office of Rural Health Policy



# 2006 Annual Report





# Table of Contents

|   |    |
|---|----|
| ORHP Overview .....   | 3  |
| FY 2006 Overview .....  | 4  |
| Budget.....   | 6  |
| Policy Activities.....  | 8  |
| Regulations and Key Policy Activities:.....                           | 8  |
| Special Projects and Partnerships:.....                               | 11 |
| Provider-Focused Technical Assistance .....                           | 13 |
| Health Information Technology .....                                   | 14 |
| Health Care Workforce .....   | 15 |
| Program of All-Inclusive Care for the Elderly (PACE) .....            | 16 |
| Women’s Health Issues.....  | 17 |
| Frontier Health .....   | 17 |
| Collaboration with the National Rural Health Association (NRHA) ..... | 17 |
| Border Health .....   | 19 |
| Research and Policy Grant Programs .....                              | 21 |
| Rural Health Research Centers .....                                   | 21 |
| One Year Rural Health Research Grant Program .....                    | 24 |
| Frontier Extended Stay Clinic Program.....                            | 26 |
| Hospital-State Based Grant Programs .....                             | 28 |
| Medicare Rural Hospital Flexibility Grant Program (Flex) .....        | 30 |
| Small Rural Hospital Improvement Grant Program (SHIP).....            | 32 |
| State Offices of Rural Health Grant Program .....                     | 34 |
| Community-Based Grant Programs.....                                   | 36 |
| Rural Health Care Services Outreach Grant Program.....                | 38 |
| Delta States Rural Development Network Grant Program .....            | 40 |
| Network Development Grant Program.....                                | 42 |
| Network Development Planning Grant Program.....                       | 44 |
| Rural Access to Emergency Devices .....                               | 46 |
| Public Access to Defibrillation Demonstration Projects.....           | 48 |
| Black Lung Clinics Grant Program.....                                 | 49 |
| Small Health Care Provider Quality Improvement Grant Program .....    | 51 |
| Radiation Exposure Screening and Education Program.....               | 53 |
| ORHP Staff.....   | 54 |
| Appendix – Authorizing Legislation .....                              | 58 |



## ORHP Overview

The Office of Rural Health Policy (ORHP) coordinates rural health policy issues within the U.S. Department of Health and Human Services. In FY 2006, ORHP administered 15 grant programs with a focus on capacity building at the community and State levels. While located within the Health Resources and Services Administration (HRSA), the Office has a department-wide responsibility to analyze the impact of departmental policy on rural communities.

ORHP is both a policy and programmatic resource for rural communities. The Office's policy role is created by Section 711 of the Social Security Act, which charges the Office with advising the Secretary on rural health issues. In that role, the Office examines issues such as the effects of Medicare and Medicaid on rural citizens' access to health care, specifically on the viability of rural hospitals and the availability of rural physicians.

The Office's programs also provide funding at both the community and State levels to support improved rural health care delivery. Through its community-based programs, the Office supports projects that improve access to health care services, encourage network development among rural health care providers, enhance delivery of emergency medical services and place and train people in the use of automatic external defibrillators. In FY 2006, the Office also assumed duties for two additional grant programs, overseeing the Black Lung Clinics grant program and the Radiation Exposure Screening and Education grant program. While these programs are not solely focused on rural health issues, many of the populations affected reside in rural areas. The Office's hospital-State programs provide grants to the States to support State-wide activities via the 50 State Offices of Rural Health and to work with rural hospitals across the Nation.

In addition, the Office is also charged with two agency-wide coordinating functions. The Office manages HRSA's border health activities. Much of the 2,100-mile U.S.-Mexico border is rural and the urban regions face health care delivery challenges similar to rural areas, such as limited health workforce capacity and a fragile infrastructure. In FY 2006, the Office also assumed a new function for HRSA by serving as the primary coordinator of intergovernmental affairs for all Agency activities.

For information about the legislative authorization for ORHP's programs, please see the appendix.

## FY 2006 Overview

The Office had a typically busy year in FY 2006, with a variety of noteworthy programmatic and policy accomplishments. At the beginning of the year, the Office identified health information technology (HIT) as a key priority. Toward that end, the Office held its first-ever national meeting on HIT for rural health care providers. The conference, which looked at the critical link between HIT and quality improvement, drew more than 500 participants from across the Nation for a two-day meeting that addressed HIT challenges and opportunities for rural health care providers. The meeting showed that there is a high interest among rural providers in learning more about how HIT can be used in rural communities to improve quality of care in rural communities. The success of the conference highlighted the need to ensure that rural providers are part of the larger national discussion on HIT adoption.

The Office also continued to focus on improving health quality in rural communities in the past year. The Office implemented the Small Health Care Provider Quality Improvement grant program by awarding funds to 15 grantees to focus on targeted improvement in diabetes and cardiovascular health.

The Rural Hospital Flexibility Grant program continued its success on a number of levels. The number of rural hospitals converting to "Critical Access Hospital" (CAH) status topped the 1,200 threshold. In addition, operating margins for CAHs continued to improve. The percent of CAHs with positive operating margins improved from 27 percent in FY 2005 to 31.1 percent by FY 2006. The median operating margin for CAHs improved from -5.2 percent to in FY 2005 to -4.2 percent in FY 2006. The Office also continued to work with CAHs on facility replacement. Many of the CAHs across the Nation are in outdated structures but often struggle to replace or modernize their existing facilities. In FY 2006, the Office released a set of

### **ORHP Vision, Mission and Strategic Goals**

#### **ORHP Vision**

ORHP's vision is to improve the health of Americans by providing national leadership in increasing access to quality health care in rural America.

#### **Mission**

The mission of the ORHP is to sustain and improve access to quality health care services for rural communities. In addition, the Office coordinates access to quality health care activities along the U.S.-Mexico border.

#### **Goals**

In order to measure its accomplishments, the office has established the following three long-term goals:

**Goal 1:** Improve the health and wellness of people living in rural communities and in the U.S.-Mexico border region.

**Goal 2:** Improve the financial viability of small rural hospitals, rural health clinics, and other rural providers.

**Goal 3:** Sustain and improve access to outpatient, inpatient, pharmaceutical, and emergency room care for rural communities and along the U.S.-Mexico border.

publicly available “model blueprints” for a CAH replacement facility. These “model blueprints” can be obtained at no cost and modified to meet individual community needs. This helps CAHs avoid some of the initial costs of planning by providing a common template from which to work. They are available at:

<http://www.hud.gov/offices/hsg/hosp/prototype.pdf>

<http://www.hud.gov/offices/hsg/hosp/hsghospi.cfm>

The Office also identified performance measurement as a key priority in FY 2006. The Office has identified draft performance measures for all of its programs over the past year and began work with the HRSA Office of Information Technology on the development of an electronic data collection tool that is compatible with the Electronic Handbook used by grantees to submit their non-competing continuation guidance. This system is expected to be operational by FY 2009.



# Budget

Chart 1 – Budget Summary

| Labor-Health and Human Services-Education and Related Agencies<br>(Amounts in thousands) |                                |                                 |                                |                              |
|--|--------------------------------|---------------------------------|--------------------------------|------------------------------|
|  | FY 2005 Final<br>Appropriation | FY 2005<br>Amount to<br>Program | FY 2006 Final<br>Appropriation | FY 2006 Amount<br>to Program |
| <i>Rural Health Programs</i>   |                                |                                 |                                |                              |
| <b>Rural Health Outreach</b>   | 39,278                         | 38,005                          | 38,885                         | 37,625                       |
| <b>Rural Health Research</b>   | 8,825                          | 8,751                           | 8,736                          | 8,663                        |
| <b>Medicare Rural<br/>Hospital Flexibility<br/>Rural and Community<br/>Access</b>        | 39,180                         | 39,180                          | 63,538                         | 63,538*                      |
| <b>to Emergency Devices</b>  | 8,927                          | 8,852                           | 1,485                          | 1,285                        |
| <b>Rural EMS Training<br/>and Assistance<br/>Equipment Program</b>                       | 496                            | 480                             | 0                              | 0                            |
| <b>State Offices of Rural<br/>Health</b>   | 8,321                          | 8,044                           | 8,141                          | 7,877                        |
| <b>Denali Commission</b>   | 39,680                         | 39,680                          | 39,283                         | 39,283                       |
| <b>Radiation, Screening,<br/>Exposure and Education<br/>Program</b>                      |                                |                                 | 1,958                          | 1,623                        |
| <b>Black Lung</b>  |                                |                                 | 5,951                          | 5,901                        |
| <i>Total, Rural Health<br/>Programs</i>  | \$ 144,707                     | \$ 142,992                      | \$ 167,977                     | \$ 165,795                   |

*Note: Individual line items may include funding for more than one grant program. For example, the Rural Health Outreach line item includes funding for the Rural Health Care Services Outreach, Rural Network Development, Network Planning, Small Health Care Provider Quality Improvement, Frontier Extended Stay, and Delta Network grant programs. The Medicare Rural Hospital Flexibility Grant line includes funding for the Flex, Small Hospital Improvement, and Delta Health Initiative grant programs. The policy line item includes funding for the Rural Health Research Center grant program as well as all of the Office's policy activities. Also, the Flex Line for FY 2006 includes \$25 million above the base to fund the Delta Health Initiative.*

Chart 2 - Total number of ORHP grants and amounts by State, in FY 2006

| State                          | # Grants Awarded | FY 2006 Funding | State                 | # Grants Awarded | FY 2006 Funding      |
|--------------------------------|------------------|-----------------|-----------------------|------------------|----------------------|
| AK                             | 6                | \$ 1,278,278    | MT                    | 14               | \$ 2,791,843         |
| AL                             | 9                | \$ 2,106,843    | NC                    | 6                | \$ 1,631,060         |
| AR                             | 6                | \$ 2,223,840    | ND                    | 7                | \$ 1,597,929         |
| AZ                             | 7                | \$ 1,401,321    | NE                    | 12               | \$ 3,013,053         |
| CA                             | 7                | \$ 1,638,352    | NH                    | 7                | \$ 1,383,302         |
| CO                             | 8                | \$ 2,487,952    | NJ                    | 1                | \$ 146,400           |
| CT                             | 2                | \$ 229,659      | NM                    | 13               | \$ 2,470,822         |
| DE                             | 2                | \$ 249,400      | NV                    | 6                | \$ 1,176,594         |
| FL                             | 8                | \$ 1,776,624    | NY                    | 11               | \$ 1,841,548         |
| GA                             | 12               | \$ 2,669,244    | OH                    | 8                | \$ 2,123,101         |
| HI                             | 3                | \$ 706,806      | OK                    | 5                | \$ 1,629,947         |
| IA                             | 10               | \$ 2,551,573    | OR                    | 8                | \$ 1,707,626         |
| ID                             | 5                | \$ 1,214,095    | PA                    | 8                | \$ 1,478,505         |
| IL                             | 8                | \$ 2,905,358    | RI                    | 1                | \$ 141,600           |
| IN                             | 7                | \$ 1,469,561    | SC                    | 7                | \$ 1,554,780         |
| KS                             | 4                | \$ 1,770,130    | SD                    | 7                | \$ 1,852,658         |
| KY                             | 11               | \$ 3,113,860    | TN                    | 7                | \$ 1,702,972         |
| LA                             | 11               | \$ 2,672,574    | TX                    | 13               | \$ 3,092,321         |
| MA                             | 6                | \$ 776,643      | UT                    | 5                | \$ 1,119,056         |
| MD                             | 5                | \$ 1,022,657    | VA                    | 7                | \$ 1,562,392         |
| ME                             | 8                | \$ 1,697,125    | VT                    | 4                | \$ 690,437           |
| MI                             | 15               | \$ 2,968,040    | WA                    | 7                | \$ 2,110,493         |
| MN                             | 9                | \$ 2,794,651    | WI                    | 7                | \$ 1,952,746         |
| MO                             | 8                | \$ 2,338,720    | WV                    | 5                | \$ 2,158,840         |
| MS                             | 8                | \$ 2,497,892    | WY                    | 5                | \$ 1,042,704         |
| <b>Total Number of Grants:</b> |                  | <b>366</b>      | <b>Total Funding:</b> |                  | <b>\$ 88,533,927</b> |





# Policy Activities

Policy Coordinator: Carrie Cochran  
Grants Project Officer: Erica Molliver

## Regulations and Key Policy Activities:

In its policy role, the Office focuses on issues related to access to care for residents of rural areas. Because many of the policy levers at the Federal level are related to the Medicare program, Medicare policy review and analysis comprise much of the Office's policy work. However, significant time and attention are also devoted to other policy areas including Medicaid, the State Children's Health Insurance Program, workforce, quality, and health information technology (HIT).

The specific Medicare regulations that come through ORHP for review vary somewhat from year to year, however the major Medicare payment system regulations generally come through for review during both the proposed rule-making and final rule-making cycles. Recently, regulations relating to the Medicare Advantage, Medicare Drug Benefit, and various quality reporting programs also have been reviewed for comment.

Medicaid and SCHIP are State-based programs and much of the discretion for these programs is left to the States. However, ORHP does participate in the departmental review of Medicaid and SCHIP waiver proposals to assure that the interests of rural Medicaid beneficiaries are considered. Our role in workforce policy encompasses a wide variety of issues including Medicare Graduate Medical Education, J1-Visa Waivers, the National Health Service Corps, and Title VII programs that provide support to rural providers. Rural Health quality issues are relatively new to the Office, as they are to Federal programs in general, but review and input into quality measurement and reporting programs has become a regular and important activity.



*Key Policy Accomplishments:*

During Fiscal Year 2006, the policy staff in ORHP reviewed approximately 50 draft Federal regulations and policies to determine how they might affect rural providers and the individuals they serve. Of these regulations, ten included provisions ORHP staff felt had the potential to adversely affect rural providers or for which staff felt additional language should be added to provide adequate protections for rural providers.

ORHP often identifies issues of particular concern to rural providers during its review of the Medicare payment system regulations. The FY 2007 Inpatient Prospective Payment System (IPPS) regulations included changes to the weighting of IPPS diagnosis-related groups (DRGs) and changes to the occupational mix adjustments for the wage index. ORHP analyzed the effects of these changes on rural providers and will continue to monitor their effects as they are implemented in the coming year. Additionally, ORHP worked closely with Center for Medicare and Medicaid Services (CMS) in revising the FY 2006 IPPS regulations regarding Critical Access Hospital (CAH) facility relocation and supported its final policy. During FY 2006, the Office continued to work with CMS on the CAH relocation Interpretive Guidelines to encourage CMS to establish reasonable flexibility for CAHs as these facilities proceed through the relocation process.

The CY 2007, Outpatient Prospective Payment System (OPPS) regulations offered us the opportunity to provide assistance to CMS in developing a payment add-on for certain rural hospitals. ORHP worked with CMS to review data and payment policies that ultimately resulted in a payment add-on for a subset of rural hospitals that were determined to have the most need. Additionally, Office staff worked with CMS to ensure that Essential Access Community Hospitals (EACHs) are treated as Sole Community Hospitals (SCHs) for OPPS payment purposes.

During FY 2006, regulations process, ORHP worked closely with CMS to revise several definitions of rural used for both CAHs and other rural providers. These revised definitions will assure that hospitals in areas considered rural under several different definitions will continue to be considered rural for purposes of Medicare payment.

In FY 2006, the ORHP worked internally with HRSA to recommend increasing flexibility in eligibility criteria for the J1 Visa Waiver program. In FY 2006, the Office of Global Health Affairs lowered the required HPSA score for placement

of a J1-Visa waiver physician in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) from 14 to 7. This allowed more FQHCs and RHCs to potentially qualify for placement of a J1-Visa waiver physician.

In FY 2006, for the first time the Quality Improvement Organizations (QIOs) were required to engage Critical Access Hospitals (CAHs) and small rural hospitals and encourage participation in reporting quality measures to the Hospital Compare website operated by CMS. If CAHs chose to participate, they were asked to provide baseline and re-measurement figures for the measures and demonstrate improvement on at least one or more of the measures. The measures address the same medical conditions that are required to be addressed by other hospitals; however, there are fewer measures for these smaller facilities. By the end of FY 2006, approximately 60 percent of CAHs have voluntarily chosen to participate. This is significant. Hospitals paid under the Medicare Inpatient Prospective Payment System (IPPS) get a full payment update if they submit quality data. CAHs, which are not paid under the IPPS, get no payment boost for reporting quality data. Studies show the CAHs voluntarily report their data because they believe it is the right thing to do for the consumer.

ORHP continues to act as primary staff for the HHS Secretary's Rural Task Force and the National Advisory Committee on Rural Health and Human Services (NAC). In FY 2006, the NAC issued its annual report to the Secretary, which focused on access to pharmacy services, health information technology, and family care giver support for the elderly in rural areas. In 2006, the NAC will complete its 2007 report, which topics include Medicare Advantage, Substance Abuse, and Head Start in rural areas.

In FY 2006, ORHP funded the *Rural Policy Analysis Cooperative Agreement* to support research and analysis on key policy issues affecting rural communities. The 2006 funding supported several activities including work with rural community colleges on health workforce issues, the Rural Policy Research Institute Rural Health Panel, and the Rural Hospital Issues Group. The RUPRI Rural Health Panel provides science-based, objective policy analysis to Federal policymakers. Panel members come from a variety of academic disciplines and create documents that reflect the consensus judgment of all panelists. The Rural Hospitals Issues Group, a panel of small rural hospital administrators and rural hospital finance experts from across the country, discuss issues such as the MMA, Medicare Advantage, and other policy issues affecting small rural hospitals.

## Special Projects and Partnerships:

One of the unique aspects of the Office of Rural Health Policy is its entrepreneurial nature. Since its inception, the Office has put an emphasis on working with key partners and organizations to develop projects to address long-standing rural health problems. The Office uses a portion of its funding in the Policy/Research line to support these activities. The emphasis of these special projects is either to highlight an issue or work with key rural partners to develop services or resources that fill an identified need.

Some of these “special projects” are focused on the needs of all rural communities, such as the need for general information on rural health. Others may focus only on a specific issue such as the recruitment and retention of health workforce or the role of economic development in health care. Still other activities focus on a particular type of health care providers. In each case, however, the projects and initiatives supported by the Office meet an identified rural health care need.

The *Rural Assistance Center* (RAC) is one of the best examples of this investment. In its authorizing statute, the Office was charged by Congress with establishing and maintaining “a clearinghouse for collecting and disseminating information on rural health care issues, including rural mental health, rural infant mortality prevention, rural occupational safety and preventive health promotion, research findings relating to rural health care and innovative approaches to the delivery of health care in rural areas.” The need for such a resource was further heightened by the findings of “One Department Serving Rural America,” a report by the Rural Task Force of the U.S. Department of Health and Human Services to the Secretary. This report identified the need for a single coordinated point of contact on rural issues for all the HHS programs that affect rural communities. The RAC was established in December 2002 as a rural health and human services “information portal.” RAC helps rural communities and other rural stakeholders access the full range of available programs, funding, and research that can enable them to provide quality health and human services to rural residents. Services provided include RAC's Web site ([www.raconline.org](http://www.raconline.org)), electronic mailing lists, and customized assistance. The site has had over 6,000,000 visits since inception and averages more than 25,000 visits per month. RAC has an average turnaround time of less than 24 hours for individual requests. In FY 2006, the RAC continued to expand the level and breadth of information and services for rural residents. In addition, the project also added

new sites and information resources related to border health issues and health disparities in the Delta region of the country.

Another long-standing effort of the Office examines the important link between economic development and health care in rural communities. The health sector is often one of the top employers in a rural economy, a role and relationship that often is not fully understood. The *Center for Rural Health Works* (RHWks) is an ongoing program that works to strengthen local systems of health. As the national focal point, it provides technical assistance, tools and training to help States measure the economic impact of the health-care sector on local, regional and State economies. It also develops feasibility studies for new health care services. During FY 2005 RHWks activities included conducting two regional workshops, responding to more than 300 requests for technical assistance, developing models for measuring the economic impact of a CAH and a FQHC on local communities and sharing the results of their studies/activities at 16 regional and national conferences.

The *National Association of Counties* (NACo) has established a partnership with Center for Rural Health Works to help county elected officials take the lead in conducting a comprehensive community engagement process for health and economic development. The purpose of this project is to help communities recognize that improving their health care system has a direct and positive impact on local economic growth. This was a new initiative for FY 2005 and continues in FY 2006. During this first year of the program, the NACo Project produced three county-level reports on economic impact, community need, health services directory, and data/information. The reports were provided to each county and placed on the NACo Web site. NACo also disseminated information about this project through workshops at its Western Regional and Annual Conferences and through articles in NACo's publication "County News."

ORHP's support for the *National Conference of State Legislatures* (NCSL) augments an existing cooperative agreement through the Bureau of Primary Health Care which provides funding support to the NCSL for an annual meeting focusing on a key rural health issue of interest to rural State legislators. With 2006 funds, NCSL convened a day-long conference to look at State-based resources that focus on rural health issues, including grants such as the State Offices of Rural Health program and the Rural Hospital Flexibility program. The meeting also examined issues related to health information technology.

## **Provider-Focused Technical Assistance**

ORHP works to develop and provide technical assistance (TA) and information sharing for rural health care providers to strengthen and expand their ability to provide quality health care. ORHP's provider-focused TA and information sharing efforts in 2006 involved Rural Health Clinic TA Conference Calls, 340B TA for Rural Hospitals, the Delta Rural Hospital Performance Improvement Project, and the Alaska Rural Hospital Performance Improvement Project.

ORHP funds supported a contract to conduct the Rural Health Clinic (RHC) TA Conference Call Series, which provided Rural Health Clinics (RHCs) nationwide with eight conference calls in FY06 on RHC policy and operational issues. The topics were determined approximately one month before each call by an advisory group of RHC experts. FY 2006 funds supported the cost of phone lines, speakers and administration of the eight one hour-long calls. The topics covered included billing and coding, Medicare Advantage, Pandemic Influenza, benchmarking, shortage designation application, and RHC basics, among others. The calls attracted an average of 200 participants each. These technical assistance calls provide substantial benefits to RHCs, which typically cannot send staff to technical assistance conferences or seminars. Not only are RHCs unable to function without key billing or clinical staff in the Office, but most RHCs simply cannot afford the cost of travel, registration, etc. associated with attending such an event. A recent estimate shows that these calls save RHCs an average of \$900 per call. In the aggregate, this results in savings of \$180,000 per call for the participating RHCs.

As a result of a change in the law in 2003, approximately 350 rural hospitals qualified to participate in the 340b Drug Pricing Program. To assist these facilities in signing up for the program, the ORHP provided supplemental funding to the HRSA Pharmacy Services Support Center (PSSC) in FY 2006 to assist rural hospitals in understanding and applying for participation in the 340b discount drug purchasing program. The PSSC is a resource established in 2002 to assist HRSA grantees and eligible health care sites to optimize the value of the 340B Program and provide clinically and cost effective pharmacy services that improve medication use and advance patient care. The PSSC operates under a contract between the American Pharmacists Association (APhA) and the Office of Pharmacy Affairs (OPA), in the HRSA Healthcare Systems Bureau. To date, over 180 rural hospitals are participating in the 340b program as a result of this assistance.

The ORHP has also partnered with the Appalachian Regional Commission (ARC) for a two-year pilot program to increase access to affordable medications by improving the management of patient assistance program (PAPs) at clinics located within the ARC and Delta Regional Authority (DRA). As a result of joint ARC/DRA PAP workshop meetings, enhancements to PAP programs have been identified and are being implemented at clinics in KY, OH, MS, and MO.

The Delta Rural Hospital Performance Improvement Project (RHPI) is designed to increase access to quality health care services in the Mississippi Delta by improving the financial, operational, and clinical performance of its small rural hospitals. On-site technical assistance is available to 122 hospitals in eight States. This project is also developing and implementing a performance improvement strategy based on the Balanced Scorecard (BSC) technology. In 2006, the Delta RHPI Project carried out a range of activities. It delivered TA to 17 unique hospitals, including 11 Performance Improvement Assessments (PIAs), 10 Targeted Consultations and Balance Scorecard (BSC) consultations in three hospitals. Additionally the project made tools available through the project Web site, conducted sustainability meetings in four States, surveyed all assisted hospitals regarding project success, and made numerous presentations about this project. The project has conducted both process and outcomes evaluations.

The Alaska Rural Hospital Performance Improvement Project, new in FY 2005, provided on-site technical assistance to hospitals in Alaska that request assistance. The TA was targeted at helping these hospitals improve their financial, clinical, and operational performance. FY 2006 funds supported three on-site TA visits to Alaska hospitals, as well as follow-up services to provide assistance during the implementation of recommendations made during the site visits.

## **Health Information Technology**

There is an established link between the benefits of health information technology (HIT) adoption and quality improvement. There also is an emerging need for support for rural providers to make informed decisions about how to implement or enhance the use of HIT in their facilities. As noted earlier, the Office made HIT a priority in FY 2006. In an effort to work toward rural equity of HIT adoption, ORHP hosted the first national meeting focused solely on rural HIT issues and challenges. The meeting, "Health Information Technology: A Provider's Roadmap to Quality" took place September 21-23, 2006 in Kansas City, MO. The meeting provided an opportunity for rural providers to learn about the basic components of HIT, focus on the initial steps of strategic planning

for HIT investments and share best practices and lessons learned about HIT implementation. The event was successful in bringing together 500 rural providers, vendors, and other interested parties to discuss strategic planning for HIT investments.

In other efforts to further the adoption and implementation of HIT by rural providers, ORHP provided funding to the *Technical Assistance and Services Center* to develop key expertise, partnerships and tools for critical access hospitals (CAHs) to consider as they look to invest in HIT. With FY 2006 funding, the Technical Assistance and Services Center for the Rural Hospital Flexibility program (TASC) will deliver tools and a customized portal. The tools will identify key areas of expertise needed to assist CAHs in their clinical, financial, leadership, and staffing domains, most likely in the form of a primer on HIT. The portal will be a customized space for knowledge sharing, access, and workspace on the AHRQ HIT portal site for the CAHs and other rural health care providers.

### **Health Care Workforce**

The Office of Rural Health Policy also sponsors two projects meant to support improved access to quality health care services by supporting the Nation's health care workforce.

The *National Rural Recruitment and Retention Network* (3RNet) works to increase the number of providers practicing in rural America. The project consists of 43 State-based, not-for-profit organizations that encourage and assist physicians and other health professionals in locating practices in underserved rural communities. Members include State Offices of Rural Health, Primary Care Offices, Primary Care Associations, Area Health Education Centers, and other not-for-profit entities.

During FY 2006, 3RNet helped States improve their retention and recruitment activities especially for primary care physicians, RNs, dentists, pharmacists, and mental health professionals. Members placed 725 medical professionals. 3RNet also maintained a toll-free phone line to assist providers interested in serving rural America. This included 207 family practice physicians, 57 internal medicine physicians, 45 pediatricians, 90 dentists, 74 nurse practitioners, and 77 physician assistants.

The 3RNet coordinated workshops, training, and presentations for those interested in recruiting and keeping providers in rural communities. In addition,



3RNet is working with HRSA programs to promote effective recruitment and retention into areas served by these programs.

The 3RNet provides substantial savings to rural communities. Research from the 3RNet shows that physician recruitment costs often cost up to \$20,000 and non-physician recruitment costs often run more than \$2,000. In FY 2006, it is estimated that there will be 725 placements through 3RNet which will result in up to \$8.97 million in saved recruiting costs for rural communities.

### **Program of All-Inclusive Care for the Elderly (PACE)**

Rural America has a higher percentage of older residents per capita than urban areas. Access to long term care services continues to be a concern in many rural communities. In FY 2006, ORHP concluded a contract that examined the utility of adapting a unique approach to caring for the frail elderly that to date had only been offered in urban areas. The Program of All-inclusive Care for the Elderly (PACE) allows frail seniors to avoid being placed in a nursing home by taking part in a comprehensive care program that coordinates preventive, primary, acute, and long-term care services. It is a unique capitated managed care benefit for the frail elderly provided by a not-for-profit or public entity that features a comprehensive medical and social service delivery system. There is little or no penetration of this model into rural areas and the PACE contract has helped to determine the level of interest among rural communities.

For the past four years, the Office provided funds to the National PACE Association to educate rural providers about the PACE model and provide consultation on how to set up a program in a rural market. This project garnered a great deal of interest from a variety of rural health organizations across the Nation. That interest culminated in the creation of a new grant program to help rural organizations in a bill that passed Congress in FY 2006.

The Deficit Reduction Act (DRA) of 2005, Section 5302 (c) (7) includes the Rural PACE Grant Program. This program is managed by the Centers of Medicare and Medicaid (CMS) and allowed for \$7.5 million in grants to be awarded so that organizations are provided with start-up funds. These start-up funds will help organizations proceed with the development and implementation of a rural PACE site in their community. ORHP worked with staff from CMS on the reviews and 15 grantees were chosen in September to receive funding.

## **Women's Health Issues**

In FY 2006, the ORHP provided funding to support the 2006 National Rural Women's Health Conference, titled "Expanding the Agenda for Rural Mental Health Services Research: Focus on the Rural Woman." Objectives of this rural women's health conference are to reveal how the unique characteristics of rural communities and the diverse needs of rural women and families may impact their mental health status and to identify and explore best practices and models with an emphasis on capacity-building, infrastructure, and leadership development to facilitate collaborative, community-based mental health services research. The rural adaptation of the healthy eating and physical activity tools of the Bright Futures Initiative, which ORHP continues to guide, will aid rural women and adolescent girls by providing information on recommended preventive health services so that they seek care based on their individual needs and share in the decision-making about their health services. The tools also encourage rural practitioners to make all health care visits an opportunity to offer preventive care. The Bright Futures rural adaptation project was accepted as a poster presentation at the 2006 Steps to a HealthierUS National Prevention Summit. Final versions of these materials are expected at the end of CY 2006 for distribution.

## **Frontier Health**

Funding for a frontier health project supports the Frontier Education Center, which provides technical assistance to individuals seeking information on frontier health care issues and produces 3-4 issue papers on frontier health-specific topics. Funding supported papers focusing on topics including the use of health information technology for public health activities in the U.S.-Mexico Border region, the applicability of the Frontier Extended Stay Clinic model to sites in the "lower 48," and developing baseline information to analyze the impact of the Medicare drug benefit on frontier communities with a sole pharmacy.

### **Collaboration with the National Rural Health Association (NRHA)**

The Office of Rural Health Policy collaborates with the National Rural Health Association (NRHA) to identify, analyze, and address rural health needs.

The purpose of one of the collaborative efforts, the *Rural Medical Educators' Conference and Technical Assistance*, is to share innovative ways to get more

medical professionals into rural areas as well as discuss new issues in rural health education. This ongoing program supports the planning and execution of the Rural Medical Educators Annual Conference, to be held in May 2007. The conference will bring together about 50 physicians, students, residents, and professors who strive to bring medical professionals (including doctors and nurses) into rural environments.

In response to issues brought to the forefront by the Institute of Medicine's 2005 rural health quality report "Quality through Collaboration," the NRHA launched a Quality Initiative which continues to improve quality of health care in rural communities. In FY 2006, funds supported in-depth technical assistance through eleven site visits to rural facilities requesting targeted technical assistance. These visits are designed to promote health care quality in rural areas. In addition, a manual on quality improvement models will be produced and distributed to rural communities. Finally, the rural quality focus group continues to meet to identify needs and develop solutions to address them.

In FY 2006, the NRHA focus on Quality supported several activities including planning a quality conference and bringing in four speakers, two meeting breaks and audio visual equipment rental at the Quality Conference in the Summer of 2007.

Public health and emergency preparedness is a long-standing need among rural communities. Funds in FY 2006 have been directed to support the development of one chapter in a rural public health textbook in collaboration with the Association of Schools of Public Health, the Council for Education in Public Health, and other partners. Public health will also be a focus at the 2007 Annual NRHA Conference via a pre-conference workshop, with an expected 40 participants.

The Office of Rural Health Policy also collaborates with the NRHA to hold several policy forums throughout the year for key stakeholders to discuss various issues, such as Medicare, Medicaid, acute care, etc. The forums educate participants about rural community-based health models and begin developing reports on best practices.

Further, an ongoing Annual Meeting Support project supports various parts of the National Rural Health Association's annual meeting. The annual meeting brings together the broad rural health community for continuing education and networking. FY 2006 funding was provided to support eight sessions on topics such as rural Health Information Technology; an overview of findings from the

National Advisory Committee's report on family caregiver support for rural elderly; Federal, State, and local measurement activity in quality small rural hospitals; FLEX performance measurement; an update from HRSA's Office of Rural Health Policy (ORHP) and Bureau of Primary Healthcare (BPHC); and a Medicare update coordinated with the Centers for Medicaid and Medicare Services (CMS).

Another collaborative effort between ORHP and NRHA supports State Rural Health Association Grants to support the rural health community at the State level through a variety of different activities. It is a continuing project. With FY 2006 funding, 42 grants of \$9,500 were administered to support activities such as rural health newsletters, conferences, educational activities, skill building, etc.

Other collaborative efforts with the NRHA resulted in the *Ag Health* program that provides technical assistance in order to raise awareness of health and safety issues associated with agriculture, decrease the number of related accidents and illnesses and improve treatment. In FY 2006, NRHA distributed a recently developed peer-reviewed brochure on respiratory hazards to over 5,000 farm workers and health care providers working in farm safety. Also in FY 2006, the NRHA produced and disseminated guidelines for Critical Access Hospitals to contract with hospice services, part of its effort to promote options for rural palliative care.

Finally, no health care effort can be successful without competent and informed health care professionals. In FY 2006, NRHA held the first Rural Clinicians' Conference which trained over 200 rural healthcare professionals and emphasized agriculture-related disease and injury. ORHP supported travel and honoraria for six conference speakers along with other supportive services for the conference.

### **Border Health**

ORHP also facilitates intra-agency border health activities that cut across the Bureaus and Offices of HRSA. In FY 2006, funds supported the *Border Health Clearinghouse in the Rural Assistance Center*, which developed a border Web site within the RAC ([www.raconline.org](http://www.raconline.org)) for health and human services information. This bilingual site serves as a clearinghouse for information on border health issues. The border health Web site was launched on schedule in January 2006.

In FY 2006, ORHP also supported the *U.S.-Mexico Border Health Association Meeting* and *Immunizations in the Americas Weeks*. The purpose of the former was

to further educate clinicians and community workers about HRSA programs and the progress toward achieving U.S.-Mexico Border 2010 Health Objectives. ORHP supported the annual U.S.-Mexico Border Health Association Meeting in Laredo, Texas, through the provision of logistical support for educational seminars for providers.

The purpose of the *Pan-American Health Organization Immunizations* program is to further educate clinicians and community workers in the appropriate use of vaccines and to facilitate the vaccination of children and adults in local clinics and community health centers along the US-Mexico border. FY 2006 funding provided logistical support for Immunization in the Americas Week.

In FY 2006 HRSA and ORHP organized a Border Health Summit in Tucson, AZ on August 22-24, 2006. Approximately 100 attendees participated, representing HRSA border grantees; key border, bi-national, and Federal partners. Plenary sessions included updates on border initiatives from the Pan American Health Organization, U.S.-Mexico Border Health Association, U.S.-Mexico Border Health Commission, and State-specific initiatives. Sessions covered the pandemic flu, HIV/AIDS sponsored programs, and border workforce analysis. Primary care and oral health research and education programs were described, including diabetes, the Border Infectious Disease Surveillance (BIDS) project, health literacy, and an analysis of diabetes/tuberculosis findings. A presentation on environmental issues and their impact was followed by a comprehensive overview of demographic projections and their subsequent impact along the U.S.-Mexico border.

The presentation of success stories from each State's prior years' bi-national border health week celebrations set the stage for the State break-out sessions. State teams met to network and discuss current health care challenges and prioritize identifiable needs and recommendations.



# Research and Policy Grant Programs

## Rural Health Research Centers

*Program Coordinator:* Joan Van Nostrand

The Rural Health Research Centers (RHRCs) Program is designed to help policy makers understand the problems that rural communities face in assuring good health and access to health care for their members. The RHRCs study issues facing rural communities in their quest to secure adequate, affordable, quality health services for their residents. This is the only Federal program that is entirely dedicated to producing policy-relevant research on health care and population health in rural areas. The work done by the Centers is also critical to helping the Office play its policy role within the Department. The research done by the RHRCs help provide important data and findings to the office's policy staff which they bring to bear in their annual review of key Departmental regulations.

### At A Glance

Amount Awarded:

2004: \$ 4 million

2005: \$ 4.4 million

2006: \$ 4 million

Grants Awarded:

2004: 8 new awards

2005: 8 continuing awards

2006: 8 continuing awards

In FY 2006, 8 noncompetitive awards were made to the research centers, in eight States, totaling \$4,000,000.

### *Changes to the Program:*

The eight RHRCs conducted 25 research projects and wrote 30 policy briefs and technical reports about their results. All RHRCs have Web sites which highlight their rural research results.

### *Key Program accomplishments:*

Research Centers study a wide variety of issues about the rural health care infrastructure and health status of members of rural communities. Some examples from the 30 briefs and reports include:

- Medicare Part D: First snapshot of enrollment in Medicare Part D in rural as compared to urban areas showed higher enrollment in stand-alone prescription drug plans (PDP) balanced by low enrollment in Medicare Advantage PDP.
- Critical Access Hospitals: Administrators of Critical Access Hospitals described their experiences with contracts offered by Medicare Advantage Plans and provided advice to others dealing with this issue.
- Medicaid: Insights into the potential rural impact of Medicaid policy changes showed that some could adversely affect the rural health infrastructure or the ability of rural residents to access services.
- Quality: An assessment of the capacity of a sample of rural hospitals to implement medication safety practices showed that the majority are using pharmacy computers. However, a significant proportion either do not have a pharmacy computer or are not using it for clinical purposes.
- Substance Abuse: Rates of methamphetamine use were higher for rural young adults. Those in smaller rural counties, in particular, were twice as likely to use methamphetamine than urban young adults.
- Disability: Rural as compared to urban adults aged 65-69 lived a greater percent of their lives with a disability. Women lived longer, more disabled lives than men. African Americans lived shorter, more disabled lives than Whites. Persons with more than twelve years of education lived substantially longer, less disabled lives than those with less education.
- Health Insurance: Examination of annual out-of-pocket health care expenditures of those under age 65 who were continuously insured by a private plan looked at the issue of underinsurance. Despite private insurance, those in rural, as compared to urban, areas paid for a substantial portion of their own health care costs.
- Health Professions: Rural Community Health Centers (CHCs) had a higher proportion of vacancies for major clinical disciplines and reported greater difficulty filling positions compared to urban CHCs. Physician



recruitment in rural CHCs is heavily dependent on National Health Service Corps scholarships, loan repayment programs, and international medical graduates with J-1 visa waivers.

- Bioterrorism: Roles of the State Offices of Rural Health in preparing for bioterrorism and other health system emergencies varied considerably across States. In some, the Office had significant involvement as a source of information for rural constituents. In others, the role was as a source of information on behalf of rural constituents. Most offices were involved in activities related to development of an emergency preparedness (EP) response plan for the State or regions within the State. A major role was in the assessment of training needs of emergency personnel and of EP of rural hospitals.

In conclusion, others have recognized the outstanding work of the Research Centers. Twenty articles were published in peer-reviewed scientific journals, such as Health Affairs, Journal of the American Medical Association, and Journal of Rural Health. The National Rural Health Association gives an award to an outstanding rural researcher at its annual meeting. Since the year 2000, five of the directors and staff of Rural Health Research Centers have received the award as a special recognition of the contributions their research has made to rural America.

## One Year Rural Health Research Grant Program

*Program Coordinator:* Erica Molliver

The One Year Rural Health Research Grant program provides one year of funding for policy-oriented rural health care services research projects. Grantee research findings help to inform the Office as well as National, State, and local decision-makers about current rural health care services issues. Research findings have been instrumental in bridging gaps between policy and program needs, and have complemented the larger scale projects conducted by the eight Rural Health Research Centers. This grant program is unique in its dual mission of both enhancing policymakers' knowledge of rural health, and expanding the pool of experienced rural health care services researchers.

These grants provide up to \$150,000 per grantee. Four awards were made on September 1, 2005 with FY05 funds, and three awards were made on September 1, 2006 with FY06 funds. All four grantees awarded in FY05 are currently on a one-year no-cost extension and are completing their final projects.

### At A Glance

#### Amount Awarded:

2004: \$ 1,018,642

2005: \$ 590,574

2006: \$ 449,923

#### Grants Awarded:

2004: 7 new awards

2005: 4 new awards

2006: 3 new awards

#### States:

ORHP awarded 3 grants to 3 States in 2006: MA, MT, MO

*Changes in the Program:*

*Key Program accomplishments:*

FY05 grantees generated research findings in the following areas:

- "Diabetes Burden and Lack of Preventive Care in the Rural United States"
- "Rural and Frontier Hospital Patients with Ambulatory Care Sensitive Conditions: Predictors of Health Care Quality and Improved Outcomes Utilizing HCUP Data"
- "Evaluation of an Outpatient Modified Rx Form"
- "Rural-Urban Differences in Nursing Home Admissions, Service Usage, and Discharge"

FY06 Grantees began research projects in the following areas:

- "Preventive Care: Supports and Barriers to Best Practices for a National Sample of Rural Medicare Beneficiaries"
- "Diabetes and Obesity: Is There a Rural-Urban Difference in the Burden?"
- "Descriptive Analysis of the Health Status of a National Asbestos-Related Cohort"

## Frontier Extended Stay Clinic Program

*Project Officer:* Carrie Cochran

The purpose of the Frontier Extended Stay Clinic (FESC) Cooperative Agreement Program is to examine the effectiveness and appropriateness of a new type of provider, the FESC, in providing health care services in certain remote locations.

In remote, frontier areas of the country, weather and distance can prevent patients who experience severe injury or illness from obtaining immediate transport to an acute care hospital. For residents in some of those communities, providers offer observation services traditionally associated with acute care inpatient hospitals until the patient can be transferred or is no longer in need of transport. Provision of these services requires the staffing, equipment, and quality assurance programs of an acute care hospital. However, extended stay services are not currently reimbursed by Medicare, Medicaid, or other third-party payers. For several years, officials in the State of Alaska and several State Offices of Rural Health, Primary Care Offices and Primary Care Associations have explored the development of a new provider type, or other mechanism, that would enable reimbursement of these services through the FESC model.

### At A Glance

Amount Awarded:

2004: \$ 1.5 million

2005: \$ 1.5 million

2006: \$ 1.5 million

Grants Awarded:

2004: 1 new award

2005: 1 continuing award

2006: 1 continuing award

States:

ORHP awarded 1 grant to 1

State in FY 2005

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) authorized the Centers for Medicare and Medicaid Services (CMS) to conduct a demonstration program in which FESCs would be treated as Medicare providers. Under MMA, FESCs are defined as clinics that are: 1) located in communities which are at least 75 miles away from the closest hospital or are inaccessible by public road and 2) designed to address the needs of patients who are unable to be transferred to an acute care facility because of adverse weather conditions or who need monitoring and observation for a limited period of time. In a separate recognition of the extended care services provided by some frontier clinics, an additional demonstration program to be administered by the Health Resources and Services Administration (HRSA) was established by the Consolidated Appropriations Act of 2004.

### *Changes to the Program:*

The ORHP Frontier Extended Stay Clinics Cooperative Agreement was the catalyst for a significant increase in the availability of quality health care in four frontier communities in Alaska and Washington. The Cooperative Agreement provided funding to the Alaska FESC Consortium for additional provider staff, equipment, and facility upgrades. Each site meticulously recorded every extended stay via a detailed, web-based encounter log. In addition, the Alaska FESC Consortium worked closely with State and Federal partners to craft standards, policies and procedures, regulations, and conditions of participation. They qualified the conditions under which patients can safely be monitored and observed, and when they must be transferred to a higher level of care.

In August of 2006, CMS released a notice of application for the CMS Frontier Extended Stay Clinic (FESC) demonstration. The CMS FESC demonstration program will test the feasibility of providing extended stay services to remote frontier areas under Medicare payment and regulations. The funding will be provided for three years in order for FESC sites to provide services for seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, cannot be transferred to acute care hospitals, or patients who do not need a hospital level of care but need monitoring and observation for limited periods of time. Based on our experience with the FESC Cooperative Agreement, ORHP worked closely with CMS to develop the conditions of participation for clinics participating in the CMS demo.

### *Key Program Accomplishments:*

Preliminary results of the first year of data collection indicate that the four clinics recorded 693 extended stays (two hours or greater duration). Only 6 percent of the stays were over 24 hours; 44 percent of the extended stays resulted in being discharged home, without further referral; 42 percent resulted in emergency transfer to a higher level of care; 12 percent were referred on a non-emergent basis.



## Hospital-State Based Grant Programs

The primary mission of the Hospital-State Team (HST) is to promote the improvement of: 1) rural healthcare quality; 2) access to healthcare; and 3) financial viability of rural hospitals. To accomplish this mission, HST members manage a multi-state portfolio of three State-based grants. These include: 1) the State Office of Rural Health (SORH); 2) Rural Hospital Flexibility (Flex); and 3) Small Rural Hospital Performance Improvement (SHIP) grant programs. In addition, the HST identifies and maintains relationships with key partners and stays abreast of State and regional specific rural health issues. Collectively, the HST serves as a base of knowledge and expertise on State and regional rural health issues.

The team consists of eight members. Two serve primarily as the Program Coordinator (PC) for the three State-based grants while seven (including one PC) serve as both a Project Officer (PO) for multiple State-based grants and Regional Liaison (RL) to one of five multi-State regions. In addition, several HST members serve as PO for technical assistance contracts and one is the PO for a cooperative agreement with the National Association of State Offices of Rural Health. During FY 2005, the HST reviewed and managed 141 grants with a total investment of almost \$44.0 million.

In order to provide quality customer service and help grantees improve their performance, the HST:

- Met every two weeks to share information and solve problems
- Developed and refined written roles for RLs and PCs
- Oriented new Team members on the history, intent and requirements for each of the three grant programs, including training at the Technical Assistance Support Center (TASC)
- Developed an orientation program for all new SORH Directors
- Provided feedback to grantees about their applications that included a formal presentation by the PC on SORH at each of the Regional Meetings.
- Invited the Department of Housing and Urban Development, and HRSA's Office of Performance Review, and Grants Management Office to meet with the Team and discuss their activities/responsibilities

- Held regular conference calls with all States in their Region to share information and address issues
- Worked with States to organize regional meetings to inform and address needs within their State.
- Designed and implemented a new Web template that allows States to “tell their story”
- Developed performance measures for the three grant programs
- Kept informed about issues facing hospitals and/or States including Health Information Technology, Pay for Performance, capital funding, universal services fund, etc.
- Worked to build relationships with TASC, NOSORH, AHA, AHQA, etc.



## Medicare Rural Hospital Flexibility Grant Program (Flex)

*Program Coordinator:* Steve Hirsch

The Rural Hospital Flexibility Program is a Federal initiative that provides funding to State governments to stabilize rural hospital economics, integrate emergency medical services (EMS) into the health care system and improve quality of care. Flex funds support the conversion of small rural hospitals to CAH status, which allows them to receive cost-based reimbursement from Medicare for inpatient and outpatient services. Flex funding to the States also encourages the development of collaborative systems of care in rural areas, including the CAHs, EMS providers, clinics, and other providers of high-quality, necessary health care services.

The FLEX program requires States to develop rural health plans, and funds the States to support and implement community-level outreach and technical assistance. Although focused on very small, rural hospitals, this complex intervention operates on the National, State, community, and facility levels and covers a broad range of health service issues.

### At A Glance

Amount Awarded:

2004: \$ 22.4 million

2005: \$ 22.2 million

2006: \$ 22.2 million

Grants Awarded:

2004: 45 continuing awards

2005: 45 continuing awards

2006: 45 continuing awards

States:

ORHP awarded 45 grants to 45 States in FY 2006

### *Changes to the Program:*

The FLEX program is developing performance measures to show the impact the Flex funding has on CAHs and the communities they serve. In FY 2006, the program's ongoing focus on quality improvement showed that 400 CAHs reported to the CMS Hospital Compare Web Site with quality data even though they are not required to do so. Early analysis shows that CAHs actually perform better than many urban hospitals on treating pneumonia patients.

### *Key Program Accomplishments:*

Since the inception of the Flex Program, more than 1,200 hospitals have converted to CAH status. Most of these hospitals have seen an improvement in their financial status. Most hospitals have offered new, needed services to their

communities. More than 80 percent of CAHs report engaging in activities to improve the quality of care provided to patients.

In FY 2006 the FLEX grantees assisted over 900 Critical Access Hospitals, Rural Health Networks and EMS providers with over \$11 million in direct technical assistance, services, and grants to rural communities and more than 900 CAH and small rural hospitals.

## Small Rural Hospital Improvement Grant Program (SHIP)

*Program Coordinator:* Keith J. Midberry

The purpose of the SHIP grant program is to help small rural hospitals do any or all of the following: 1) pay for costs related to implementation of prospective payment systems (PPS); 2) comply with provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996; and 3) reduce medical errors and support quality improvement (QI) efforts.

State Offices of Rural Health coordinate rural hospitals' participation in the program. In FY 2006, \$14.5 million was awarded to 1,591 eligible hospitals in 46 States and Puerto Rico, each hospital received approximately \$9,000.

*Changes to the Program:*

Since FY 2002, the first year of the program, the number of participating hospitals has increased by 141 hospitals or approximately 10% percent.

The use of SHIP funds for reduction of medical error and quality improvement activities increased from 53 percent in FY 2004 to 60 percent in FY 2005. The use of SHIP funds for HIPAA activities decreased from 39.5 percent in FY 2004 to 34 percent in FY 2005. The use of grant funds for PPS activities remains relatively constant at 6 percent.

*Key Program Accomplishments:*

During FY 2006, 60 percent of the funds (\$8.8 million) were expended for projects and initiatives related to quality improvement. HIPAA activities received 34 percent of the funds (\$5 million) and PPS activities received 6 percent (\$ 900,000) of the funds. Of the 1,591 participating SHIP hospitals, 941 or 59 percent used some or all of their grant funds to invest in health information technology (HIT).

Ninety percent (847) of the hospitals used SHIP funds to secure new or upgrade existing hardware and software infrastructure that serve as the foundation for business office, security and quality improvement functions. Ten percent (94) of the hospitals expended funds on hardware or software related to business office

### At A Glance

Amount Awarded:

2004: \$ 14.7 million

2005: \$ 14.8 million

2006: \$ 14.5 million

Grants Awarded:

2004: 49 continuing awards

2005: 47 new awards

2006: 47 continuing awards

functions such as coding, billing or accounting software. Fifty-four percent (508) identified their HIT expenditures as specific to compliance with the HIPAA security rule and 46 percent (432) invested in HIT for quality improvement activities

## State Offices of Rural Health Grant Program

*Program Coordinator:* Keith J. Midberry

The purpose of the State Offices of Rural Health (SORH) Grant Program is to assist States in strengthening rural health care delivery systems by creating a focal point for rural health within each State.

The program provides an institutional framework that links small rural communities with State and Federal resources to help develop long term solutions to rural health problems.

There are three core functions of the SORH: (1) to serve as a rural health clearinghouse of information and innovative approaches to the delivery of services; (2) to coordinate State activities related to rural health in order to avoid duplication of efforts and resources; and (3) to identify Federal, State, and nongovernmental programs regarding rural health and provide technical assistance to public and nonprofit private entities regarding participation in such programs.

Additionally, the program encourages State Offices to promote rural recruitment and retention efforts of health professionals within their State. Hence, the SORHs are the primary dues-paying members to the 3RNet. In 2006 recruited 750 health professionals of which approximately 50 percent were primary care physicians. Approximately 90 percent went to underserved areas.

In FY 2006, 50 non-competing continuation grants were awarded for a total of \$7,264,000. The maximum level of funding awarded was \$146,400, which 47 of the 50 States requested and received. The program requires a State funding match to the Federal funding at a minimum 3:1 ratio; a unique leveraging component for the program.

*Changes to the Program:*

The program was enhanced by a new five year cooperative agreement with the National Association of State Offices of Rural Health (NOSORH) which was designed to build and sustain rural health infrastructure in each State. Under

### At A Glance

Amount Awarded:

2005: \$ 7.4 million

2006: \$ 7.2 million

2007: \$ 7.2 million (anticipated)

Grants Awarded:

2005: 50 continuing awards

2006: 50 continuing awards

2007: 50 continuing awards

the agreement, NOSORH coordinates the planning and logistics for five regional grantee meetings, the State Office new directors' orientation, and the annual grantee meeting. Peer-to-peer mentoring has also been strengthened and improved under the cooperative agreement.

*Key Program Accomplishments:*

State Offices continue to leverage significant partnerships with the goal of improving rural health. In 2006, an example of the impact of these partnerships is seen through the Rural Hospital Performance Improvement project (RHPI). SORHs in Alabama, Arkansas, Illinois, Kentucky, Louisiana, Mississippi, Missouri, and Tennessee continue to work collaboratively with their State Hospital Associations (SHAs) to provide input and expertise for this project. In particular, the SORHs worked with the contractor to ensure that the on-site technical assistance was well-managed and appropriate to the needs of each hospital. The SORHs and SHAs also continue to follow up with the hospital after technical assistance is rendered.

The SORHs are continuously working with Federal, State, and local partners to improve the collaboration among safety net providers in rural areas of their States. In particular, 14 SORHs applied with their State partners to an ORHP initiative to "Improve Collaboration between Critical Access Hospitals (CAHs) and Federally Qualified Health Centers (FQHCs)." The following States applied for technical assistance under this initiative: Alaska, Georgia, Hawaii, Idaho, Montana, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Vermont, Washington, and Wisconsin. In each of these States the SORH is taking the lead in bringing together the State-level partners (Primary Care Offices, Primary Care Associations, SHA) as well as safety-net providers. The technical assistance is being provided through consultants to the State teams to assist them in better understanding the roles and relationships between CAHs and FQHCs. As a result of the leadership from the SORHs, each of the States will be developing plans and strategies for improved collaboration between the CAHs and FQHCs in their States.



## Community-Based Grant Programs

In FY 2006, ORHP administered 8 community-based grant programs with 213 grants and a combined program budget of \$48,178,350. Each community-based grant program and grant administered by the Community-Based Team (CBT) have differences, but each is predicated upon on a defined underserved population, a commitment to change and a set of linked objectives designed to build on local assets while addressing the common issues of a collapsing safety net and unique local issues.

The administration of the grants are grouped by subject or issue area, which include: access to health care, chronic diseases, community health models, health literacy and promotion, mental health and substance abuse, primary care, transitional care, and vulnerable populations. The CBT chose the subject areas based on the awards to communities. For example, almost half of the 2006 newly funded Network Development grants focused on health information technology. The team increased its focus on HIT by having two members specializing in this subject area as a resource to the grantees.

As discussed earlier most of the CBT grant programs are authorized and funded by the same budgetary funding line, the Rural Health Outreach line, which expired during the fiscal year. The 2006 report for each program will be in the context of the funding line.

As ORHP reorganized into teams, HRSA reorganized by moving the Black Lung Clinics Program and the Radiation Exposure Screening and Education Program to ORHP because both programs principally serve rural communities. The team was expanded to include the two new programs, each with their own funding line. Both programs were reviewed by OMB under the PART process during FY 2006 for changes in the program in FY 2008.

Twenty-five subject or issue areas of interest to community-based team are listed below (alphabetically) and represent the areas of need and interest of our community grants:

- Access to care
- Cardiovascular health
- Case management
- Chronic disease (Alzheimer's)
- Diabetes
- Domestic violence
- Elder care
- Emergency management services and trauma care
- Health professions education
- Health information technology
- Maternal and child health
- Mental health and substance abuse
- Nutrition
- Obesity
- Oral health
- Pharmacy
- Public health
- Quality
- Recruitment and retention
- "Safety net" collaboration
- School-based health centers
- Telehealth
- Transportation
- Uninsured
- Women's health



## Rural Health Care Services Outreach Grant Program

*Program Coordinators:* Nisha Patel and Jennifer Chang

The Rural Health Care Services Outreach Grant Program (Outreach) encourages the development of new and innovative health care delivery systems in rural communities that lack essential health care services. The projects implemented demonstrate creative models of outreach and health services delivery. The emphasis of this grant program is on service delivery through collaboration, requiring the grantee to form a consortium with at least two additional partners.

The Outreach projects are based on demonstrated community needs, calling for involvement of the community in the development and implementation of the project. Outreach projects are community-defined and the ORHP does not limit the type of health services provided, except in-patient care. This has resulted in a broad variety of health services provided, including primary health care, dental care, mental health services, home health care, emergency care, health promotion and education programs, outpatient day care, and many others. Outreach grantees also serve a wide range of population groups, including low-income populations, the elderly, pregnant women, infants, adolescents, minority populations, and rural populations with special health care needs.

In FY 2006, 65 new and 43 continuing grants were awarded in 41 States for a total of \$17,880,245.

### *Changes to the Program:*

For FY 2006, a change in the maximum amount of funding that applicants could request for the three-year budget period was implemented. Outreach applicants can request up to \$150,000 in the first budget period, \$125,000 in the second budget period and \$100,000 in the third budget period, for a total award of \$375,000. The Outreach program has also redesigned the way that grantees are assigned project officers. Twenty-three common focus areas were identified for the community-based teams, with project officers managing each. Grantees are

### At A Glance

#### Amount Awarded:

2004: \$ 19.9 million

2005: \$ 18.8 million

2006: \$ 17.9 million

#### Grants Awarded:

2004: 96 continuing awards, 13 new awards

2005: 71 continuing awards, 30 new awards

2006: 43 continuing awards, 65 new awards

assigned to project officers by the issue their grant seeks to address such as chronic diseases management, oral health, mental health, and others. This structure creates an environment where ORHP can provide specialized technical assistance, more grantee-to-grantee interaction regarding best practices, and support. In FY 2006, the Outreach program strengthened its performance improvement initiative at the programmatic and grantee level. Performance measures are being developed to meet the unique needs of the grantees. The measures will enhance the Outreach program and the quality of the services being provided by the grantees.

*Key Program Accomplishments:*

The Outreach grant program has had tremendous success in providing needed health services to rural communities. The program has helped to bring rural communities together to work towards a common goal, which is to improve the health and well-being of rural populations. Although the Outreach program is a three-year grant, many of the programs have continued success beyond the project period and Federal funding. The grantees are encouraged to develop creative sustainability and evaluation plans that allow their program to be expanded and enhanced.

## Delta States Rural Development Network Grant Program

*Program Coordinator:* Lakisha M. Smith

The purpose of the Delta States Rural Development (Delta) Grant Program is to support community organizations in the development and implementation of projects to address local health care needs in the rural Delta Region. A single grant is awarded to one organization within each of the eight Delta States (Alabama, Arkansas, Illinois, Kentucky, Louisiana, Mississippi, Missouri, and Tennessee) collectively known as the Delta Regional Authority (DRA). The eight States are comprised of 207 eligible counties.

ORHP provides support for the counties within the DRA through activities designed to strengthen the safety net and small rural hospital performance, to implement demonstration projects for improving collaboration across counties among existing grant programs and to provide technical assistance and outreach funds to small rural Delta communities.

In FY 2006, eight grants were awarded totaling \$5,090,751.

### *Changes to the Program:*

To achieve greater financial impact and partner collaboration across the Delta counties/parishes, the Delta program encouraged grantees to form multi-county consortia instead of single-county networks. Additionally, an evaluation of the program was commissioned to determine the overall effect upon the Delta region. New performance measures are being developed to enhance the quality of project activities associated with the Delta grant program.

### *Key Program Accomplishments:*

The Delta program has fostered improvements in health status, financial viability, and access to care through regional network oriented structures that are guided by local providers, capacities, and community needs. The program evaluation has demonstrated that over 94 percent of the Delta communities and

### At A Glance

Amount Awarded:

2004: \$ 5.1 million

2005: \$ 5.1 million

2006: \$ 5.1 million

Grants Awarded:

2004: 8 new awards

2005: 8 continuing awards

2006: 8 continuing awards

parishes have established functional local single county or multi-county or parish network structures through which communication and coordination was enhanced within the community. It is estimated that over 450 different agencies which included public health departments, hospitals, clinics, mental health providers, community health centers, faith based organizations, local school districts, universities, and governmental agencies were involved in local Delta network activities. Most significantly, approximately 3 percent of the Delta population or an estimated 136,000 people have received services or have been reached by a Delta related project.

## Network Development Grant Program

*Program Coordinator:* Sherilyn Pruitt

The purpose of the grant is to “expand access to, coordinate and improve the quality of essential health care services, and enhance the delivery of health care in rural areas.” These grants support rural providers who work together in formal networks, alliances, coalitions or partnerships to integrate administrative, clinical, technological, and financial functions across their organizations. The funds provided through this program are not used for the direct delivery of services. The ultimate goal of the RHND Grant Program is to strengthen existing health care networks in order to achieve business (network partner return) and social (community return) competencies that increase access and quality of rural health care and, ultimately, the health status of rural residents.

### **At A Glance**

**Amount Awarded:**

2004: \$ 6.6 million

2005: \$ 7 million

2006: \$ 6.7 million

**Grants Awarded:**

2004: 29 continuing awards, 5 new awards

2005: 27 continuing awards, 10 new awards

2006: 15 continuing awards, 23 new awards

**States:**

ORHP awarded 38 grants to 25 States in FY 2006

Twenty three new grants and 15 continuing grants were funded in FY 2006 (38 total grants) totaling \$6,668,686.

### *Changes to the Program:*

The Office of Rural Health Policy (ORHP) hired additional project officers and reorganized the manner in which grants were allocated to project officers. The new allocation assigns grantees to project officers by issue area instead of program. This has resulted in fewer grants per project officer and allows project officers to develop areas of expertise that may be shared across programs. The program also held a two-day grantee meeting in conjunction with the Rural Health Network Planning Grant Program. This provided opportunities for training, networking, and face-to-face interaction with the ORHP project officers.

### *Key Program Accomplishments:*

The 38 Network Development grantees encompass over 400 individual organizations and represent a wide variety of public and private entities that support the health of rural communities. The network member organizations include many diverse partners such as critical access hospitals, universities, health departments, community health centers, and social service providers. All of the Network Development grantees have made progress streamlining processes and systems between network members. A large majority of the grantees this year have focused on improving the quality of health care delivery and staff development activities, including staff training, and recruitment and retention. Implementing or improving health care technology, including streamlining payer information, educating staff, reducing medical errors, enforcing HIPAA regulations, providing resources for clients, and implementing telemedicine, was also the focus of Network grantee activity. As required by the grant, all grantees focused on sustainability, and grantee plans for sustaining their program once Federal funding ceases, included obtaining additional grants, partnering with State and local government agencies, procuring private investors, soliciting membership dues/fees from partners and offering cost-based products and services.

## Network Development Planning Grant Program

*Program Coordinator:* Eileen M. Holloran

The purpose of the Rural Health Network Development Planning Grant Program is similar to the Network Development Grant Program in that it seeks to “achieve efficiencies; expand access to, coordinate and improve the quality of essential health care services; and strengthen the rural health care system as a whole.” These grants support rural communities needing assistance in planning, organizing and developing a health care network. Funds cannot be used for direct delivery of health care services. The grant supports one year of planning to develop a network and help them become operational.

### At A Glance

Amount Awarded:

2004: \$ 1 million

2005: \$ 1.6 million

2006: \$ 1.2 million

Grants Awarded:

2004: 12 new awards

2005: 19 new awards

2006: 15 new awards

States:

ORHP awarded 15 grants to 15 States in FY 2006

Fifteen new grants were awarded in fiscal year 2006 totaling \$1,222,256.

*Changes to the Program:*

No changes to the program in 2006.

*Key Program Accomplishments:*

In FY 2006 the Rural Health Network Development Planning Grant Program awarded \$1,222,356 to 15 grantees for one-year projects.

The focus of the awards varied widely from developing Statewide Electronic Medical Record systems in Wyoming to providing Mental Health Services to the Hispanic/Latino population in Connecticut.

Ohio University, a new awardee, has begun work on a project focused on activities to develop partnerships for strengthening the community's ability to identify, refer, and coordinate comprehensive care to children with developmental and behavioral disabilities in 19 rural Appalachian Counties. This project received national recognition when the project was chosen for a presentation at the National Rural Health Association Meeting in May 2007.

In 2007 several former Planning grantees were contacted by telephone to learn if they were continuing the Planning network activities that were begun with grant funds. Most of those contacted said they not only were still working together but that they had collaborated on other activities and expanded the network partnerships since the Planning grant ended.

Additionally, for FY 2007, two of the five new Rural Health Network Development Grant awardees were FY 2006 Planning grantees.



## Rural Access to Emergency Devices

*Program Coordinator:* Sheila Warren

The purpose of the Rural Access to Emergency Devices (RAED) Grant Program is to provide funding to rural community partnerships to purchase automated external defibrillators (AEDs) that have been approved, or cleared for marketing by the Food and Drug Administration; and provide defibrillator and basic life support training in AED usage through the American Heart Association, the American Red Cross, or other nationally recognized training courses. The legislation that created this program states that awards will be made to community partnerships. A community partnership is composed of local emergency response entities such as community training facilities, local emergency responders, fire and rescue departments, police, community hospitals, and local non-profit entities and for-profit entities.

### At A Glance

Amount Awarded:

2004: \$ 9.2 million

2005: \$ 7.4 million

2006: \$ 309,408

Grants Awarded:

2004: 49 continuing awards

2005: 48 continuing awards

2006: 4 new awards

States:

ORHP awarded 4 grants to 3 States in FY 2006

Four new grants were awarded in FY 2006 totaling \$309,408.

*Changes to the Program:*

No changes to the program in 2006.

*Key Program Accomplishments:*

In 2006, approximately 275 AEDs were placed and approximately 650 lay persons and first responders were trained in their utilization. There were no AED uses reported. AEDs have been placed in colleges, universities, community centers, local businesses, law enforcement and ambulance vehicles, fire trucks, 911 dispatch centers, and offices. The grant creates opportunities to educate the public on AEDs via advertisements, news media, schools, churches, shopping malls, restaurants, home owner associations, businesses, local government bodies, security firms, etc. The RAED Program has resulted in an increased public awareness, increased number of AEDs available and an increase in

persons, first responders, and lay persons trained in their utilization in the event of sudden cardiac arrest.

## Public Access to Defibrillation Demonstration Projects

*Program Coordinator:* Sheila Warren

The purpose of the Public Access to Defibrillation Demonstration Project (PADDP) is to award grants to political subdivisions of States, Indian tribes and tribal organizations to develop and implement innovative, community-based programs that provide cardiopulmonary resuscitation (CPR) and automated external defibrillation (AED) to cardiac arrest victims, provide training to community members in CPR and AED usage, and to maximize community access to AEDs.

In FY 2006 four non-competing continuation grants were awarded totaling \$930,663.

*Changes to the Program:*

The program is still making the transition from a national formula-based program to a community-focused grant program with fewer grantees.

*Key Program Accomplishments:*

In FY 2006, approximately 475 AEDs were placed and approximately 559 lay persons and first responders were trained to use them. AEDs have been placed in colleges, universities, community centers, Indian reservations, local businesses, law enforcement and ambulance vehicles, fire trucks, 911 dispatch centers, sporting events, major tourist attractions, and offices. The grant has created methodologies to educate the public on AEDs via advertisements, news media, schools, churches, shopping malls, restaurants, home owner associations, businesses, local government bodies, security firms, etc.

The PADDP program has resulted in increased public awareness, increased number of AEDs available and an increase in persons, first responders, and lay persons, trained in the utilization of AEDs in the event of sudden cardiac arrest.

### At A Glance

Amount Awarded:

2004: \$ 930,663

2005: \$ 930,663

2006: \$ 930,663

Grants Awarded:

2004: 4 new awards

2005: 4 continuing awards

2006: 4 continuing awards

## Black Lung Clinics Grant Program

*Program Coordinator:* Kristin Martinsen

The purposes of the Black Lung Clinics Grant Program (BLCP) are to: (1) seek out and provide services to miners (active and inactive) with the intention of minimizing the effects of respiratory impairment or improving the health status of miners or coal miners exposed to coal dust as a result of employment; and (2) increase coordination with other services and benefits programs to meet the health-related needs of this population. Grantees provide specific diagnostic and treatment procedures required in the management of problems associated with black lung disease, which improve the quality of life of the miner and reduce economic costs associated with morbidity and mortality arising from pulmonary diseases.

### At A Glance

Amount Awarded:

2004: \$ 5.8 million

2005: \$ 5.8 million

2006: \$ 5.7 million

Grants Awarded:

2004: 13 continuing awards, 2 new awards

2005: 12 continuing awards, 3 new awards

2006: 15 continuing awards

Grantees have varied models of service delivery. BLCP services may be provided either directly or through formal arrangements with appropriate health care providers. Current clinics include Community Health Centers (Federally Qualified Health Centers), hospitals, State health departments, mobile vans, and stand alone clinics.

In FY 2006, 15 continuation grants were awarded in 13 States, totaling \$5,749,106.

*Changes to the Program:*

In July 2006, the program moved from HRSA's Bureau of Primary Health Care to the ORHP to better serve the needs of its grantees and constituents, most of whom are located in rural areas.

*Key Program Accomplishments:*

Program grantees were awarded additional outreach funding to enhance their outreach programs in FY 2005. The number of active and inactive miners seen at

the clinic increased from 9055 in FY 2005 to 10790 in FY 2006. Enhanced outreach activities included media advertisements, the development of Web sites, increased hours of outreach staff, and time dedicated to coordination of activities with community organizations.

During FY 2006, as part of the FY 2008 budget process, the program was evaluated by the Office of Management and Budget's Program Assessment Rating Tool (PART) and will be implementing new annual and long term performance measures.

## Small Health Care Provider Quality Improvement Grant Program

*Program Coordinator:* Heather Dimeris

The purpose of the Small Health Care Provider Quality Improvement Grant Program (SHCPQI) is to assist rural providers with the implementation of quality improvement strategies, while improving patient care and chronic disease outcomes. Improving the quality of chronic disease management in ambulatory care settings can improve health indicators and decrease emergency room visits and admissions to hospitals. The Small Health Care Provider Quality Improvement Grant focuses on quality improvement for chronic diseases, i.e., diabetes mellitus and cardiovascular disease.

### At A Glance

Grant Amount Awarded:  
2006: \$ 737,757  
Grants Awarded:  
2006: 15 new awards

The ultimate goal of this program is to improve health outcomes through enhanced chronic disease management in rural health care provider settings by utilizing a patient registry system; tracking and reporting specific health indicators using nationally accepted performance measures; assessing the need for quality improvement and developing additional performance measures; and participating in technical assistance through peer learning workshops with fellow Small Health Care Provider Quality Improvement Program grantees, facilitated by a quality improvement specialist.

FY 2006 was the first year of funding under the program and 15 SCHPQI grants were awarded to 13 States, totaling \$737,757 and 38 eligible applications were reviewed by an objective review committee.

*Changes to the Program:*

No changes to the program in 2006.

*Key Program Accomplishments:*

To assist the SHCPQI grantees, HRSA's ORHP awarded a technical assistance contract to Management Solutions Consulting Group to support SHCPQI

grantees with implementing quality improvement strategies and an electronic patient registry system.

## Radiation Exposure Screening and Education Program

*Program Coordinator:* Vanessa Hooker

The purpose of the Radiation Exposure Screening and Education Program (RESEP) is to assist individuals involved in mining, transporting, and processing uranium; as well as, testing nuclear weapons by identifying and preventing illnesses that may have resulted from these activities. This is accomplished by providing grants to States, local governments, and other eligible entities to establish and support programs to: 1) screen individuals for cancer and other radiogenic diseases; 2) provide referrals for medical treatment of individuals screened; 3) develop and disseminate public information and education programs for the detection, prevention, and treatment of radiogenic cancers and diseases; and 4) facilitate documentation of claims for the Radiation Exposure Compensation Act (RECA) program.

### At A Glance

Amount Awarded:  
2004: \$1.974 million  
2005: \$1.958 million  
2006: \$1.917 million  
Grants Awarded:  
2002: 6 new awards  
2003: 6 continuing awards, 1 new  
2004: 6 continuing awards  
2005: 7 new awards

In FY 2006, HRSA awarded continuation grants to seven organizations in five southwestern States (Arizona, Colorado, Nevada, New Mexico and Utah) totaling \$1,917,000.

### *Changes to the Program:*

In July 2006, the program moved from HRSA's Bureau of Primary Health Care to the Office of Rural Health Policy (ORHP) to better serve the needs of its grantees and constituents, most of whom are located in rural areas.

### *Key Program Accomplishments:*

During FY 2006, as part of the FY 2008 budget process, the program was evaluated by the Office of Management and Budget's Program Assessment Rating Tool (PART) and will be implementing new annual and long term performance measures.





## ORHP Staff

**Marcia Brand, Ph.D** – *Associate Administrator*

Budget, personnel, Government relations, operations oversight, legislation, policy and administration issues, Secretary's Rural Initiative, tribal health, oral health

**Tom Morris, MPA** – *Deputy Associate Administrator*

Budget, personnel, National Advisory Committee on Rural Health and Human Services, policy and research coordination, administrative issues

**Jennifer Riggle, JD** – *Associate Director*

Grants Program Director (program oversight), guidance preparation, re-Authorization, Division of Independent Review liaison, liaison to Grants Management and Division of Grants Policy and Grants Tracking, State-based activities

**George Brown, MPH, CHES** – *Grants Project Officer*

Delta Health Initiative Grant Program, Delta Small Rural Hospital Performance Improvement Initiative, **SOUTHEAST REGION LIAISON** (Project Officer for Southeast States in FLEX, SHIP, and State Office of Rural Health)

**Jennifer Chang, MPH** – *Grants Project Officer*

Rural Health Care Services Outreach Grant Program Coordinator. Issue Areas: women's health, maternal and child health, domestic violence, school-based programs

**Carrie Cochran, MPA** – *Policy Coordinator*

Rapid Response for Requests of Rural Data Analysis Cooperative Agreement. Rural health policy issues, including: Medicare and Medicaid payment policy, critical access hospitals, rural hospitals, workforce, health information technology. National Advisory Committee on Rural Health and Human Services and HHS Rural Task Force. Rural Medicare demonstrations including the Frontier Extended Stay Clinic model.

**Jerry Coopey, MPH** – *Grants Project Officer*

Issue Areas: Rural Recruitment and Retention Network liaison, Access to Capital,  
**MIDWEST REGION LIAISON**

**Lt. Heather Dimeris, MS, RD** – *Grants Project Officer*

Small Health Care Provider Quality Improvement Grant Program Coordinator.  
Issue Areas: health information technology, case management services, public health, dietary/ metabolic syndrome issues

**Nancy Egbert, RN, MPH** – *Senior Clinical Advisor*

Issue Areas: clinical advisor/evaluation, quality (especially hospital and primary care), nursing issues, influenza pandemic, State Hospital Team Leader,  
**NORTHWEST REGIONAL LIAISON**

**Steve Hirsch, MSLS** – *Grants Project Officer*

Rural Hospital Flexibility Grant Program coordinator, Rural Assistance Center Cooperative Agreement. Issue Areas: definitions of Rural (including Rural Urban Commuting Areas), **NORTHEAST REGIONAL LIAISON**

**Eileen Holloran** – *Grants Project Officer*

Grant Program Coordinator. Issue Areas: transportation (mobile clinics), chronic disease, and Alzheimer's

**Vanessa Hooker** – *Grants Project Officer*

Radiation Exposure Screening and Education Program, Coordinator, Rural Health Outreach and Network Development Grant Programs  
Issue Areas: Diabetes, recruitment, and retention

**Kristin Martinsen** – *Grants Project Officer*

Black Lung Clinics Program, Coordinator, Rural Health Outreach Grants  
Issue Areas: mental health and substance abuse

**Keith J. Midberry, MHSA** – *Grants Project Officer*

State Offices of Rural Health Grant Program Coordinator, Small Hospital Improvement Program Coordinator, and Human Resources Coordinator

**Erica Molliver, MHS** – *Grants Project Officer*

Single-Year Rural Research Grant Program. Rural health policy issues including: Medicare payment policy, Medicaid payment policy, rural health clinics, Health Professional Shortage Areas, National Advisory Committee on Rural Health and Human Services.

**Nisha Patel** – *Grants Project Officer*

Rural Health Care Services Outreach Grant Program Coordinator. Issue Areas: cardiovascular health, diabetes, nutrition, obesity, and elder care

**Michele Pray-Gibson, MHS** – *Grants Project Officer*

Executive Officer Liaison to the Office of the Administrator, Budget Coordinator, National Advisory Committee on Rural Health and Human Services logistics,  
**SOUTHWEST REGION LIAISON**

**Sherilyn Z. Pruitt, MPH** – *Grants Project Officer*

Network Development Grant Program coordinator. Issue Area: HIT. Project officer for Georgia Health Policy Center technical assistance contract.

**Elizabeth Rezai-zadeh, MPH** – *Grants Project Officer*

Border Health Initiative, U.S.- Mexico Border Health Commission liaison,  
**SOUTHWEST REGION LIAISON**

**Jacob L. Rueda, MPH** – *Grants Project Officer*

Project Officer for Network, Outreach, Black Lung, and RESEP Grants. Issue Areas: Rural EMS, Pharmacy, and Medicaid

**Lilly Smetana** – *Grants Project Officer*

Grants Program Assistant, Electronic Handbook liaison, File Master. Issue Areas: earmarks grants, health professions education, health literacy, and oral health

**Lakisha Smith, MPH** – *Grants Project Officer*

Delta Network Development Grant Program Coordinator, Issue Areas: HIV/AIDS, minority health, Indian/Tribal liaison, agricultural health and safety, safety net collaboration, school-based programs, and health education/promotion, and disease prevention (general)

**Vacant** – *Grants Project Officer*

Acting Intergovernmental Affairs Coordinator (State Organizations: NGA, NACO, ASTHO, NCSL, NRHA, NACCHO, Commissions, Technical Assistance Coordination) and NHRA Liaison.

**Sonja Carter Taylor** – *Grants Project Officer*

Community-based team grants project officer, Inter/Intra Agency Agreements Coordinator, contracts backup. Issue Areas: primary care access (general)

**Amal Thomas** – *Staff Assistant*

Administrative Team Coordinator, Special Assistant to the Director

**Shelia Tibbs** – *Grants Project Officer*

Project Officer, Hospital-State based team working on Flex, SHIP and State Office grant programs. Co-Regional Liaison for the Southwest

**Joan Van Nostrand, DPA** – *Research Coordinator*

Rural Health Research Centers Grant Program Coordinator. Issue Areas: aging, disability, long-term care, and palliative care

**Sheila Warren** – *Grants Project Officer*

Rural Access to Emergency Devices/Public Access to Defibrillation Demonstration Grant Program Coordinator and Contracts Coordinator. Issue Areas: health education/promotion and disease prevention (general)

**Kathryn Umali** – *Grants Project Officer*

Intergovernmental Affairs coordination; Delta Health Initiative

**Mary Collier** – *Support Staff*

Controlled correspondence coordination; travel, timekeeping

**April Ward** – *Support Staff*

Travel Coordinator, National Advisory Committee on Rural Health and Human Services; Timekeeping; Special Assistant to the Deputy Director



## Appendix – Authorizing Legislation

### *Black Lung*

Authorization: Section 427(a), Public Law 91-173 of the Federal Coal Mine Health and Safety Act of 1977 as amended by section 5(6), Public Law 92-303 of the Black Lung Benefits Act of 1972 and amended by section 9, Public Law 95-239 of the Black Lung Benefits Reform Act of 1977.

### *Delta Health Initiative Grant Program*

Authorization: Section 1820(j) of the Social Security Act 42 U.S.C. 1395

### *Delta States Rural Development Network Grant Program*

Authorization: Section 330A of the Public Health Service Act 42 U.S.C. 254c

### *Frontier Extended Stay Clinics Demonstration*

Authorization: Section 301 and 330A of the Public Health Service Act 42 U.S.C. 241 and 254c.

### *Medicare Rural Hospital Flexibility Grant Program*

Authorization: Section 1820(j) of the Social Security Act 42 U.S.C. 1395

### *Network Development Grant Program*

Authorization: Section 330A of the Public Health Service Act 42 U.S.C. 254c

### *Network Development Planning Grant Program*

Authorization: Section 330A of the Public Health Service Act 42 U.S.C. 254c

### *Policy Oriented Rural Health Services Research Program*

Authorization: Section 711 of the Social Security Act 42 U.S.C. 912

### *Public Access to Defibrillation Demonstration Projects*

Authorization: Section 313 of the Public Health Service Act 42 U.S.C. 245 as amended by section 159(c), P.L. 107-188 of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002.

*Radiation Exposure, Screening and Education Program*

Authorization: Section 417C of the Public Health Service Act as amended by section 4, Public Law 106-245 of the Radiation Exposure Compensation Act Amendments of 2000.

*Rural Access to Emergency Devices Grant Program*

Authorization: P.L. 106-505, Title IV – Cardiac Arrest Survival Act, Subtitle B, section 413 of the Public Health Improvement Act 42 U.S.C. 254c.

*Rural Health Outreach Grant Program*

Authorization: Section 330A of the Public Health Service Act 42 U.S.C.

*Rural Health Research Centers Program*

Authorization: Section 711 of the Social Security Act 42 U.S.C. 912

*Small Health Care Provider Quality Improvement Grant Program*

Authorization: Section 330A of the Public Health Service Act 42 U.S.C. 254c

*Policy-Oriented Rural Health Services Research Program*

Authorization: Section 711 of the Social Security Act 42 U.S.C. 912

*Small Rural Hospital Improvement Grant Program*

Authorization: Section 1820(g)(3) of the Social Security Act 42 U.S.C. as amended by section 4201(a), P.L. 105-33 of the Balanced Budget Act and section 405(f), P.L. 108-173 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

*State Offices of Rural Health Grant Program*

Authorization: Section 338J of the Public Health Service Act 42 U.S.C. 254r as amended by section 301, P.L. 105-392.